



Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

New Agency Provider Enrollment Instructions

“Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time.”

-Provider Relations

New Provider Enrollment Instructions

- Anyone becoming a *new* Home Help agency provider
- Register for Single Sign On and CHAMPS
- Fill out the New Provider Enrollment Application
- Track Your Application

***Have paper and a writing utensil nearby

*****You must complete the application within 30 days of beginning it**

Call the Provider Support Helpline if you need assistance:

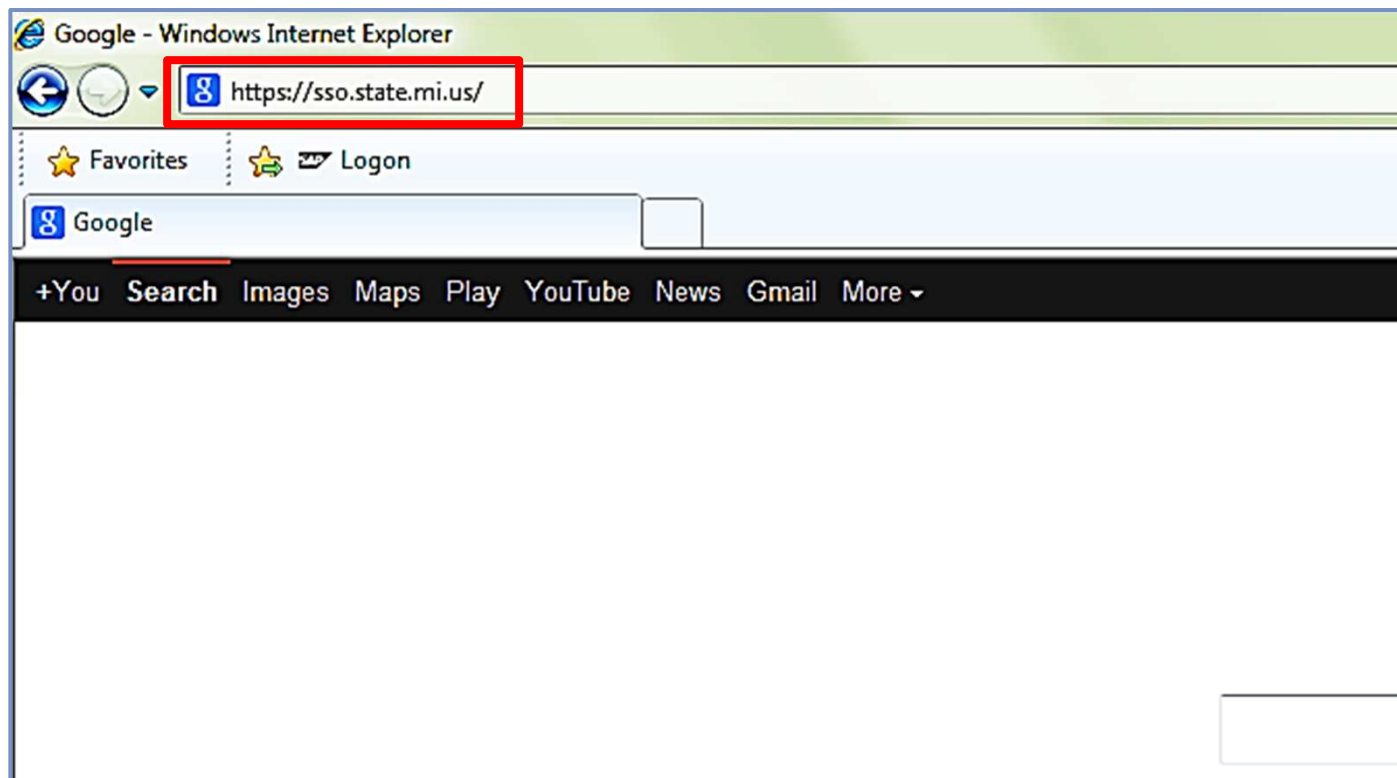
1-800-979-4662

Register for Single Sign On and CHAMPS

Single Sign On is a website that allows a user to enter one name and password in order to access multiple applications.

CHAMPS is the Community Health Automated Medicaid Processing System. Providers will enroll, update enrollment information, and report services performed in this system.

Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.) and type **https://sso.state.mi.us/** into the search bar.



Providers must register a SSO User ID before gaining access to the site.
Select the **Register** button from the State of Michigan Single Sign On page.

State of Michigan Single Sign On

INT

Please Login or Sign-Up to use Single Sign-On

Login

User ID:

Password:

Forgot Password?

If you have forgotten your password, click Need Password.
Single Sign-On system will email you a new temporary password.

Sign-Up

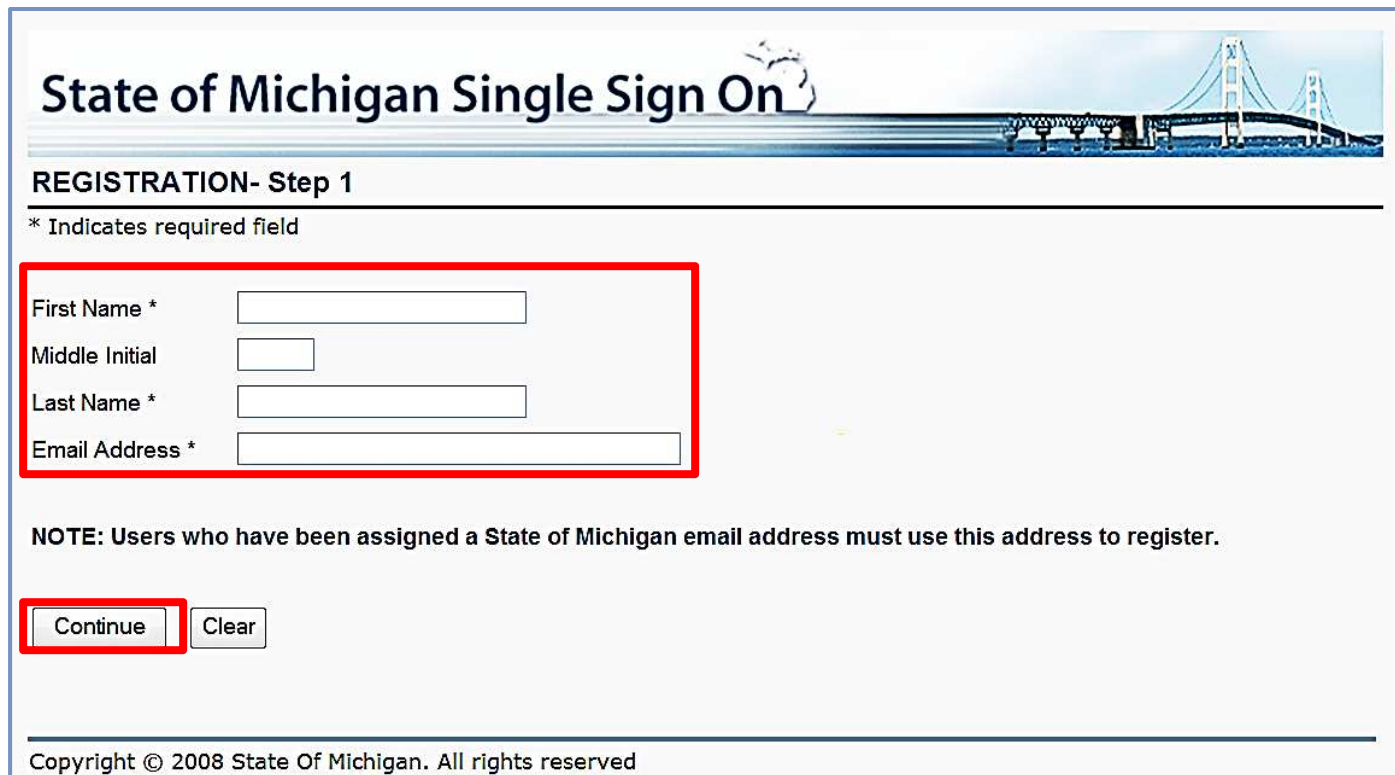
If you are a new user to Single Sign-On, click Register to create your User ID and Password.

[Michigan.gov Home](#) | [Help/FAQs](#) | [Contact Us](#)

Fill in the required information, indicated by the star (*): *First Name, Last Name, and Email Address.*

Make sure the email address is correct as a temporary password will be sent there.[†]

Click **Continue**.



The image shows a web form titled "State of Michigan Single Sign On" with a background image of a bridge. Below the title is the section "REGISTRATION- Step 1". A note states "* Indicates required field". There are four input fields: "First Name *", "Middle Initial", "Last Name *", and "Email Address *". The "Continue" button is highlighted with a red box. At the bottom, there is a copyright notice: "Copyright © 2008 State Of Michigan. All rights reserved".

State of Michigan Single Sign On

REGISTRATION- Step 1

* Indicates required field

First Name *

Middle Initial

Last Name *

Email Address *

NOTE: Users who have been assigned a State of Michigan email address must use this address to register.

Copyright © 2008 State Of Michigan. All rights reserved


[†] If you currently do not have an email address, you can create one for free from a number of service providers. A simple internet search for "free email account" will display several options.

Enter a four digit number, or click to allow the system to generate one for you.

Type the number outlined in blue in the empty white box above (this is a security measure).

Click **Continue**.

State of Michigan Single Sign On



REGISTRATION- Step 2


Please Enter a four digit number to create a unique UserID : [Why should I enter this number?](#)

(OR)

Please generate a random four digit number for me : ☐ Yes ☒ No

Enter the number as it is shown in the box below * :

21653




Copyright © 2008 State Of Michigan. All rights reserved

You will receive a confirmation page as shown below. The information you entered is displayed for review before it is submitted to the SSO system.

If corrections need to be made, click **Back** and make corrections.
If the information is correct, click **Submit**.

State of Michigan Single Sign On



USER REGISTRATION CONFIRMATION

Please review the following information. Click Submit

First Name	: John
Initial	:
Last Name	: Doe
Email Address	: doe51487@gmail.com
Your User Id will be	: doe3636

Copyright © 2008 State Of Michigan. All rights reserved

Confirm information is correct

Click **Close** button.

State of Michigan Single Sign On

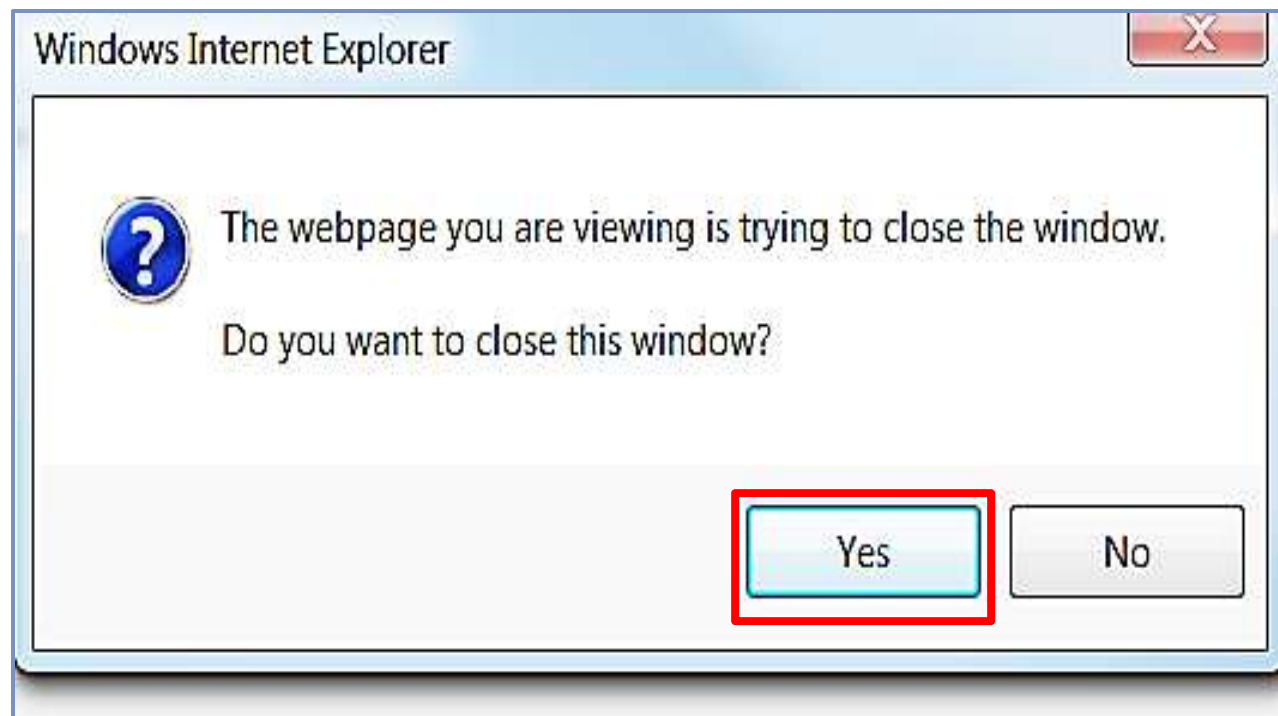


Your request to be registered to the Michigan Web Site is being processed. You will receive an Email within 24 hours with your User Id and password.

Close

Copyright © 2008 State Of Michigan. All rights reserved

A dialog box identical to the one below will appear.
Click **yes**.



An email will be sent to the email address you supplied in the registration process. Check that email for a message from SSO_Administrator@michigan.gov that includes your **User ID** and **Temporary Password**.

***NOTE: You will only have **48 hours** to use the temporary password before it expires.

***NOTE: You may need to check your **Junk** or **SPAM Mail** folders as sometimes this email will be sent there instead of your inbox. Please make sure your email will allow you to receive emails from SSO_Administrator@michigan.gov.

***All user accounts are created with a temporary password that can only be used once and *must* be used within the **48 hour** time frame.

New UserId Information from State of Michigan Single Sign ON

SSO_Administrator@michigan.gov 7:19 AM (14 minutes ago)

to me

[Michigan Business OneStop Users click here to login](#)

[All Other Application Users click here to login](#)

The following new UserId has been created for you:

Owner Name:	John Doe
User Id:	doej3636
Password:	5vukm98j
Time of service provision:	Aug 13, 2014 07:19:23 EDT

If you are a new Single Sign On account user and have any problems accessing your account, please contact the State of Michigan Client Service Center at 241-9700 or [1-800-968-2644](tel:1-800-968-2644).

The email includes a link back to the SSO login page to change the password.

Click the **All Other Application Users click here to login** link.

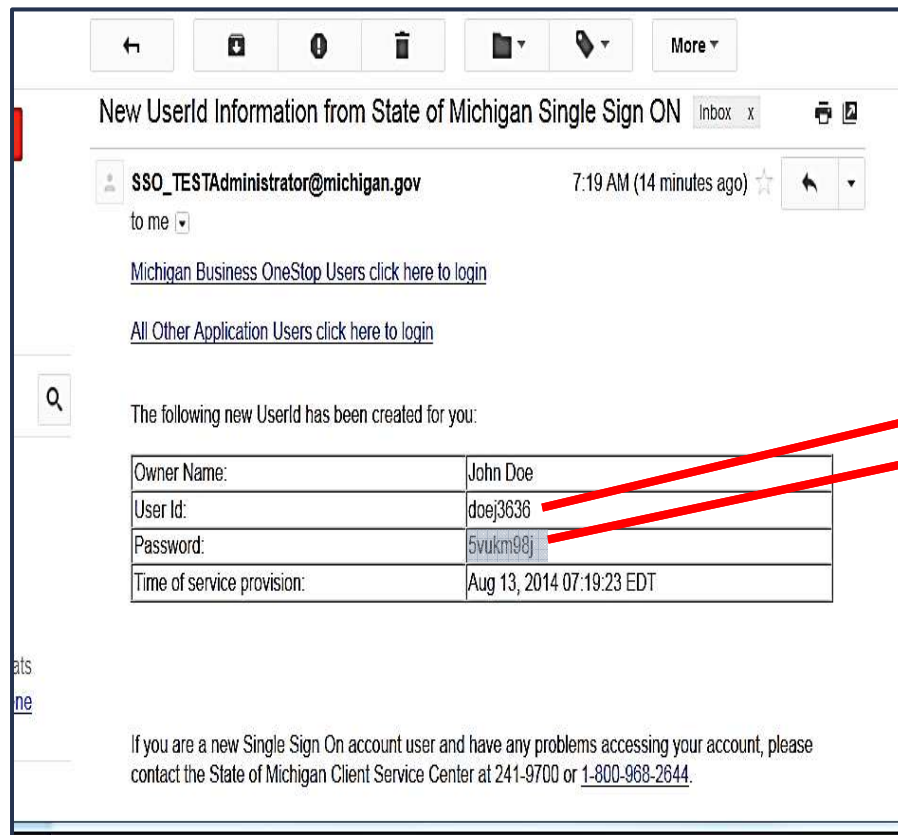


***NOTE: If the link is broken or does not direct you back to the SSO login (see next step), enter <https://sso.state.mi.us/> into the search bar of your web browser.




Enter your User ID and temporary password in the corresponding boxes in the SSO login. Click **Login**.

*****NOTE: Highlight** your temporary password from the email by double-clicking on it, **right click** on the **highlighted** password, and select **copy** from the menu. Then **right click** the password box in SSO and select **paste** from the menu.

New UserId Information from State of Michigan Single Sign ON Inbox x

 **SSO_TESTAdministrator@michigan.gov** 7:19 AM (14 minutes ago)  

to me 

[Michigan Business OneStop Users click here to login](#)

[All Other Application Users click here to login](#)

The following new UserId has been created for you:

Owner Name:	John Doe
User Id:	doej3636
Password:	5vukm98j
Time of service provision:	Aug 13, 2014 07:19:23 EDT

ats
ne

If you are a new Single Sign On account user and have any problems accessing your account, please contact the State of Michigan Client Service Center at 241-9700 or [1-800-968-2644](tel:1-800-968-2644).

State of Michigan Single Sign On

Please Login or Sign-Up to use Single Sign-On

Login

User ID:

Password:

Forgot Password?

If you have forgotten your password, click Need Password.
Single Sign-On system will email you a new temporary password.

Because the password is temporary, you will be informed the password has “expired” and will be prompted to change it.

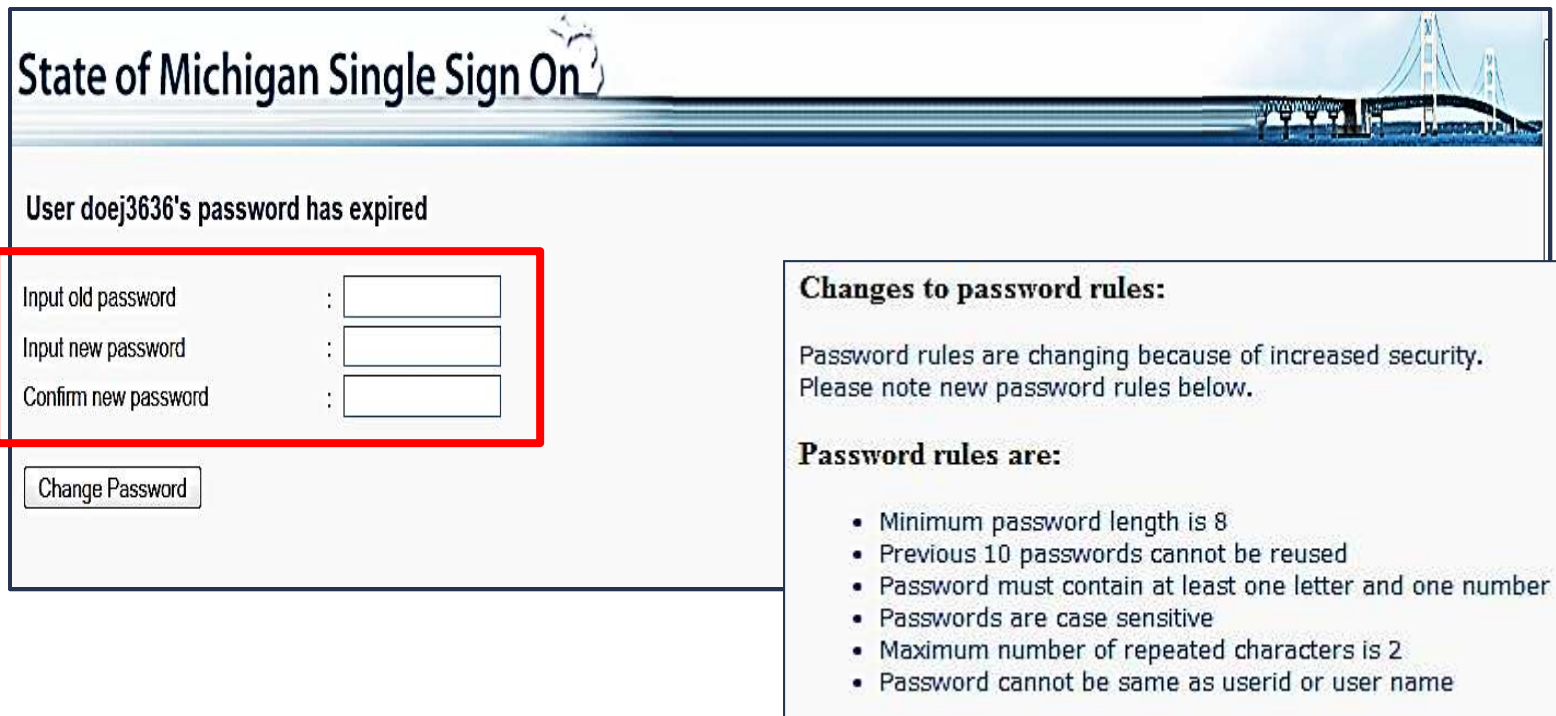
Copy and paste the old password in the corresponding box.

Choose a new password and enter it in the two corresponding boxes.

Click **Change Password**.

***NOTE: The password is *upper- and lower-case sensitive*, so be sure to enter it correctly both times (e.g. “PassWord11” is different than password11).

***NOTE: Passwords will only be accepted if they abide by *all* of the password rules listed on this page.



The screenshot shows the 'State of Michigan Single Sign On' password change page. At the top, there is a header with the text 'State of Michigan Single Sign On' and a background image of a bridge over water. Below the header, a message states 'User doej3636's password has expired'. The main form area contains three input fields: 'Input old password', 'Input new password', and 'Confirm new password', each followed by a colon and a text box. These three input fields are grouped together and enclosed in a red rectangular box. Below the input fields is a button labeled 'Change Password'. To the right of the input fields, there is a section titled 'Changes to password rules:' followed by a paragraph stating 'Password rules are changing because of increased security. Please note new password rules below.' Below this, there is a section titled 'Password rules are:' followed by a bulleted list of five rules.

State of Michigan Single Sign On

User doej3636's password has expired

Input old password :

Input new password :

Confirm new password :

Change Password

Changes to password rules:

Password rules are changing because of increased security. Please note new password rules below.

Password rules are:

- Minimum password length is 8
- Previous 10 passwords cannot be reused
- Password must contain at least one letter and one number
- Passwords are case sensitive
- Maximum number of repeated characters is 2
- Password cannot be same as userid or user name

You will be taken to a screen with four **Challenge/Response** questions. Answer all four questions and confirm your answers in the second column. Click **OK**.

This allows you to reset your password in the event you forget it in the future.

***NOTE: These answers are not case sensitive.

State of Michigan Single Sign On

User ID: scotts14 [Sign Off](#)

Change Challenge/Response Answers

Change your answers and click OK. You must provide an answer to each challenge.
Answers are **not** case sensitive.

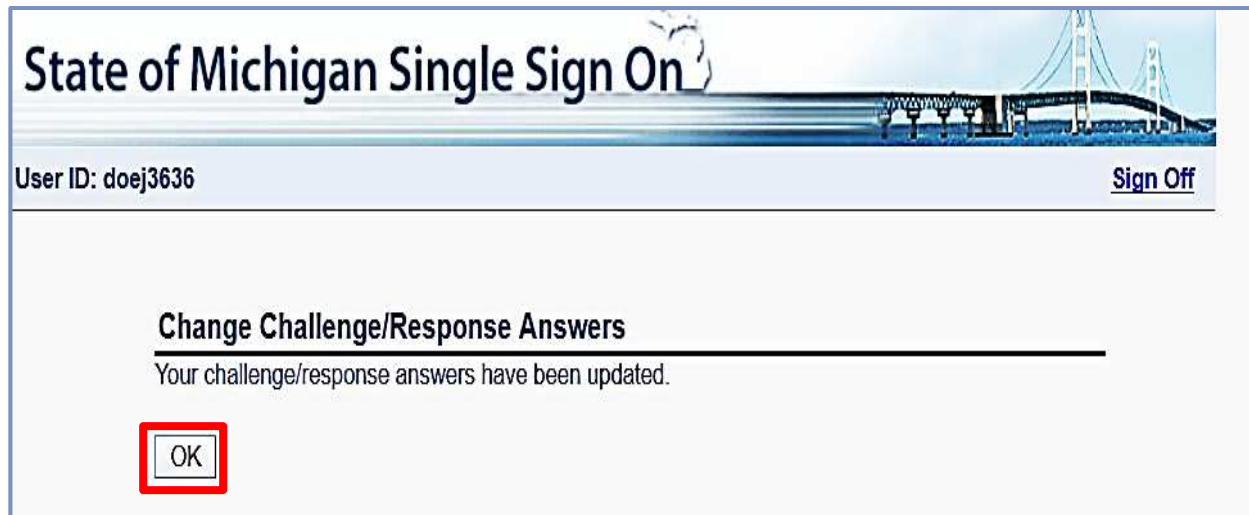
What is the name of the city in which you were born?
Answer:
Confirm Answer:

What is your fathers middle name?
Answer:
Confirm Answer:

What is your mothers maiden name?
Answer:
Confirm Answer:

What are the last four (4) digits of your social security number?
Answer:
Confirm Answer:

The following screens will be displayed.
Click **OK** on the first.
Click **Done** on the second.
You will be returned to the Application Portal.




State of Michigan Single Sign On

User ID: doej3636 [Sign Off](#)

Change Challenge/Response Answers

Your challenge/response answers have been updated.



State of Michigan Single Sign On

User ID: doej3636 [Sign Off](#)

Account Maintenance

- [Change My Personal Information](#)
- [Change My Password](#)
- [Change My Challenge/Response Answers](#)

Below is a picture of the Application Portal page.
To subscribe to CHAMPS, click on the **Subscribe to Applications** hyperlink.



The screenshot shows the 'State of Michigan Single Sign On' header with a map of Michigan and a bridge. Below the header is the 'Application Portal' title. A welcome message for 'John Doe' is followed by a password expiration notice. A message states the user is not subscribed to applications and provides a link to 'Subscribe to Applications', which is highlighted with a red box. At the bottom are links for 'Account Maintenance' and 'Sign Off'.

State of Michigan Single Sign On

Application Portal

WELCOME **John Doe**,

Your password will expire in 121 days.

You are **NOT** currently subscribed for any applications. If you wish to subscribe for application access please click on the [Subscribe to Applications](#) link below.

[Subscribe to Applications](#) [Account Maintenance](#) [Sign Off](#)

Below is a picture of the Subscription page.
From the first drop-down menu, select **DCH-CHAMPS**.
From the second drop-down menu, select **CHAMPS**.
Click **Next**.

State of Michigan Single Sign On

SUBSCRIPTION

Please Select from the list

Dept of Community health	Select App
Dept of Community health	
Dept of Civil Service	
Dept of Human Services	
Dept of Natural Resources	
Dept of Treasury	
Dept of Licensing and Regulatory Affairs	
Dept of State	
Dept of Technology Management and Budget	
Dept of Transportation	
All Departments	
DCH - CHAMPS	
Michigan State Police	
Center for Educational Performance and Information (CEPI)	
Center for Shared Solutions	
Michigan Gaming Control Board	

State of Michigan Single Sign On

SUBSCRIPTION

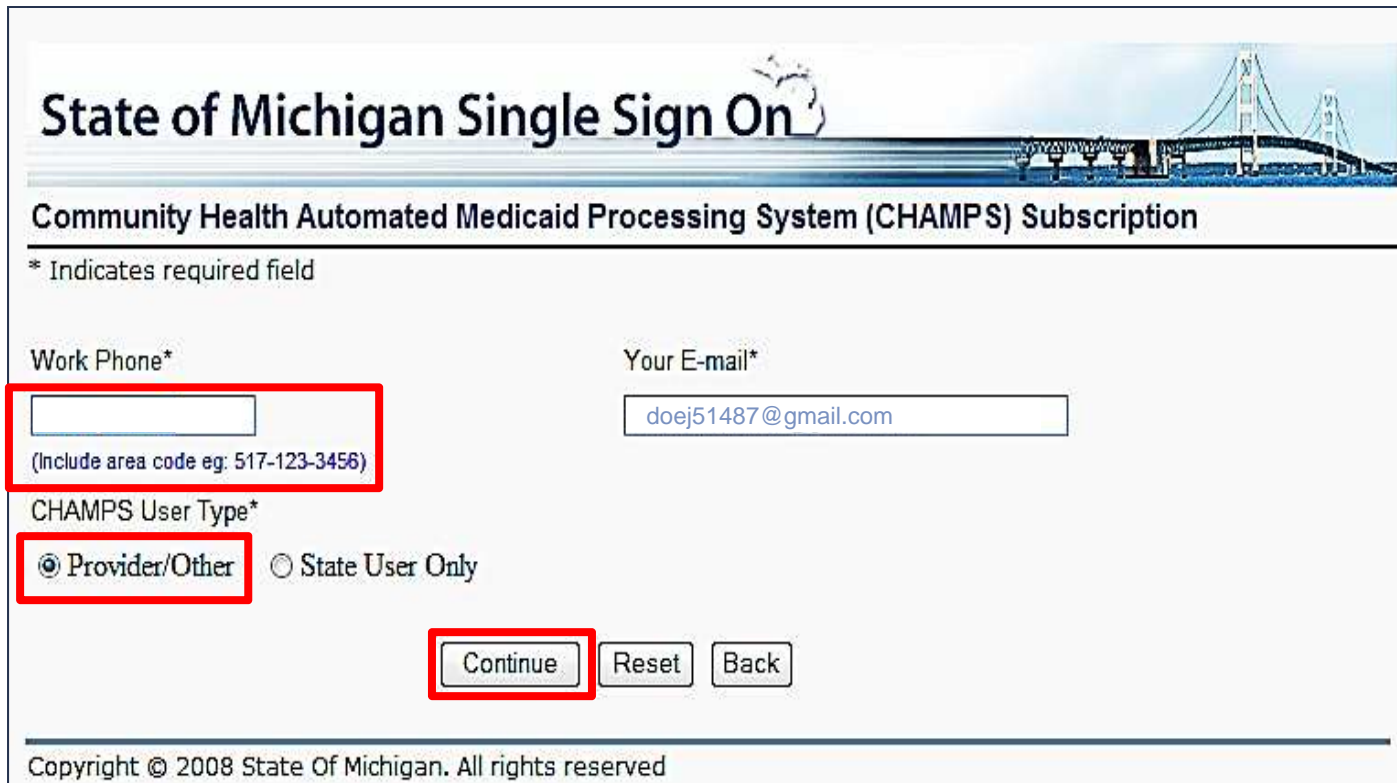
Please Select from the list

DCH - CHAMPS	Select App
	Select App
	CHAMPS
	CHAMPS - HealthBeat
	CHAMPS - ICD10 Parallel/B2B
	CHAMPS - Outreach(State Users Only)
	CHAMPS - Production CM Toolkit
	CHAMPS - Siebel(State Users Only)

Next Back

Copyright © 2008 State Of Michigan. All rights reserved

Enter your *agency's phone number*, including the area code and dashes
(For example, 123-456-7890)
Choose **Provider/Other** for CHAMPS User Type.
Click **Continue**.



State of Michigan Single Sign On

Community Health Automated Medicaid Processing System (CHAMPS) Subscription

* Indicates required field

Work Phone*

(Include area code eg: 517-123-3456)

Your E-mail*


CHAMPS User Type*

☒ Provider/Other ☐ State User Only

Copyright © 2008 State Of Michigan. All rights reserved

Review the following information.
If anything needs to be changed, click **Back**.
If everything is correct, click **Confirm**.

State of Michigan Single Sign On



User Enrollment Confirmation For: CHAMPS - HealthBeat

Please review the following information. Click Confirm or Back.

User Info

User ID	: doe3636
Email Address	: doe51487@gmail.com
Full Name	: John Doe
Phone Number	: 999-999-9999
CHAMPS UserType	: Provider

Confirm

Back

Copyright © 2008 State Of Michigan. All rights reserved

Click **Close** to close the window.

Be sure you **Sign Off** the Application Portal before advancing to the next step.

State of Michigan Single Sign On

Your subscription request has been submitted successfully. You will be notified upon approval.

[Close](#)

Copyright © 2008 State of Michigan

State of Michigan Single Sign On

Application Portal

WELCOME **Jane Doe**,

Your password will expire in 121 days.

You are currently subscribed to the following applications:

- [CHAMPS](#)

[Subscribe to Applications](#) [Add new Roles to Existing Subscription](#)
[Account Maintenance](#) [Sign Off](#)

New AGENCY Provider Application

Follow these steps to apply as a new agency.

Sign into the State of Michigan Single Sign On by going to **<http://sso.state.mi.us>** and entering your User ID and Password. This will take you to the Single Sign On Application Portal.

Google - Windows Internet Explorer

https://sso.state.mi.us/

State of Michigan Single Sign On

INTERN

Please Login or Sign-Up to use Single Sign-On

Login

User ID:

Password:

Login

Forgot Password?

If you have forgotten your password, click Need Password. Single Sign-On system will email you a new temporary password.

Need Password

Michigan.gov Home | Hel

Below is the display of the Application Portal.
Click on the **CHAMPS** hyperlink.
Read the MDCH Systems Use Notification on the next page and click **Acknowledge/Agree**.

***NOTE: You will have to do this every time you access CHAMPS

State of Michigan Single Sign On

Application Portal

WELCOME **Bill Preston,**

Your password will expire in 121 days.

You are currently subscribed to the following applications:

• **CHAMPS**

[Subscribe to Applications](#)

[Account Maintenance](#)

[Add new Roles to Existing Subscription](#)

[Sign Off](#)

State of Michigan Single Sign On

User ID: doej1111

[Sign Off](#)

MDCH Systems Use Notification

The Michigan Department of Community Health's (MDCH) computer information systems (systems) are the property of the State Of Michigan and subject to state and federal laws, rules and regulations. The systems are intended for use only by authorized persons and only for official state business.

Systems users are prohibited from using any assigned or entrusted access control mechanisms for any purposes other than those required to perform authorized data exchange with MDCH. Logon IDs and passwords are never to be shared. Systems users must not disclose any confidential, restricted or sensitive data to unauthorized persons. Systems users will only access information on the systems for which they have authorization. Systems users will not use MDCH systems for commercial or partisan political purposes.

Following industry standards, systems users must securely maintain any information downloaded, printed, or removed in any format from the systems. When no longer needed, this information must be destroyed in an appropriate manner specific to the format type.

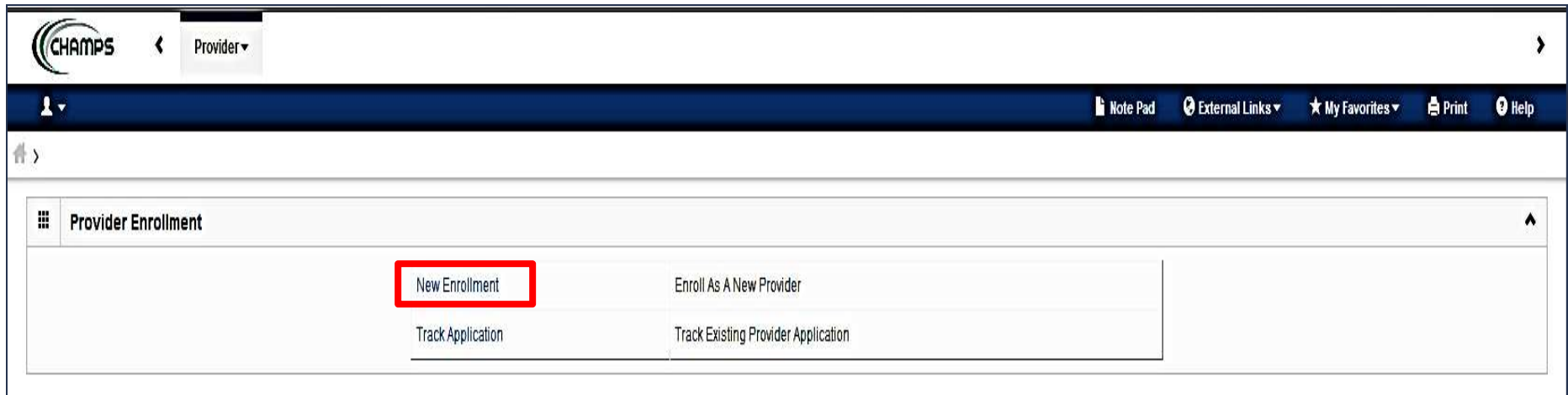
All users of the systems give their expressed consent to the monitoring of their activities on the systems. If such monitoring reveals possible evidence of unauthorized or criminal activity, the evidence may be provided to administrative or law enforcement officials for disciplinary action and/or prosecution.

By accessing information provided by the Michigan Department of Community Health computer information systems and clicking on the button below, I acknowledge and agree to abide by all governing privacy and security terms, conditions, policies and restrictions for each authorized application.

Acknowledge/Agree

Cancel

Below is the display of the CHAMPS homepage for a brand new provider.
Click on **New Enrollment** (in blue).



Choose **Atypical (non-medical) provider**.
Choose **Agency (Child Care Institution, Home Help/Personal Care...)**
Click the **Submit** button.

Scott,Sarah ▾

Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > ESV Member List > New Enrollment

Enrollment Type

Select the Applicable Enrollment Type

☐ Individual/Sole Proprietor

☐ Regular Individual/Sole Proprietor (Choose this option to be a Medicaid Individual/Sole Proprietor, you may participate in the EHR-MIPP.)

☐ EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP.)

☐ Managed Care Network Provider Only

☐ Managed Care Network Provider and EHR

☐ Group Practice (Corporation, Partnership, LLC, etc.)

☐ Billing Agent

☐ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

☐ Contractor/MCO

☒ Atypical (non-medical) provider (Choose this option if you do not have a NPI)

☐ Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

☒ Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, etc.)

Submit

Enter the required information, indicated by the asterisk (*).
Click **Confirm** to verify the EIN/TIN.
Click **Finish**.

Welcome to MMIS - Windows Internet Explorer

Print Help

Basic Information(Home Help)

Legal Entity Name: (As shown on the Income Tax Return)

Entity Business Name: * (Doing Business As)

EIN/TIN: *

NPI:

Contact Email Address:

Email-1

Email-2

Email-3

Please note that all providers are subject to a criminal background screening that could affect your ability to be paid through the Home Help program.

Page ID: dlgAddBasicInformationStep1(Provider)

Done Trusted sites | Protected Mode: Off 100%

Write down the **Application ID** number for future reference.
Click **OK**.

***NOTE: Be sure to complete and submit your application within 30 days or your application will be deleted.

Welcome to MMIS - Windows Internet Explorer

Print Help

Application ID: 20150528999673 Name: Helping Hands Chore Services

Basic Information

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: 20150528999673

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

Page ID: dlgAddBasicInformationStep3(Provider)

Done

Trusted sites | Protected Mode: Off

100%

OK

Click on the **Step 2: Add Locations** hyperlink.

Application ID: 20150709666544

Name: Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015		Incomplete	Please add/validate Location.
Step 3: Add Specialties	Required			Incomplete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count: 1

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Click **Add**.

Provider Portal > New Enrollment > HIPAA-Exempt Individual Enrollment

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Add

To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink.

Locations List

Filter By

Go

	Doing Business As	Location Type
	▲ ▼	▲ ▼
No Records		

Enter the required information, indicated by an asterisk (*).
Click **Validate Address** (you *cannot* go any further without clicking this).

***NOTE: **Location Type** will always be *Primary Practice Location*.

***NOTE: Entering the **Zip Code** will automatically update **State, City/Town, and County**

Print Help

Application ID: 20150528999673 Name: Helping Hands Chore Services

For all locations, Correspondence address is required. For Primary Practice Location, Pay-To address is required. Enter Remittance Advice address only to receive a paper Remittance Advice

Add Provider Location

Location Type: Primary Practice Location *

Doing Business As: End Date:

If a department or drawer number is required enter the information in line TWO.
(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111)
If an attention line is required, please enter the information in Line THREE.
(For example: ATTN: Billing Dept.)

Address validation successful

Address Line 1: 320 S WALNUT ST *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: LANSING *

State/Province: MICHIGAN *

County: INGHAM *

Country: UNITED STATES *

Zip Code: 48933 - 2014

Validate Address

Phone Number: (517) 373-2076 * Extn:

Fax Number:

Email Address:

Web Page:

Office Hours:

Communication Preference: CHAMPS Notice

Handicap Accessible: No

Accept 835 (reported at EIN/TIN level): No

Language(s) Spoken: English Arabic Chinese (For Multiple Selection, use Ctrl Key)

OK Cancel

Page ID: dlgEnrAddLocation(Provider)

Scroll to the bottom of the previous screen.
Enter the **Fiscal Year End Date** relevant to your agency.
Indicate the **Distinct Part Unit**.
Click **OK**.

Office Hours: Communication Preference: CHAMPS Notice

Handicap: No

Accessible: No

Accept 835 (reported at EIN/TIN level): No

Language(s) Spoken: English Arabic Chinese (For Multiple Selection, use Ctrl Key)

Facility Details

State Facility ID:

Licensed Medicaid Bed(s):

Licensed Medicaid/Medicare Bed(s): (Dual Certified)

Swing Bed(s):

Licensed LTC Unit(s): (Long Term Care)

Distinct Part Unit: None None Psych Skilled Nursing

Fiscal Year End Date: 12/31 * (mm/dd)

Licensed Medicare Bed(s):

Ventilator Dependent Unit(s):

Acute Care Bed(s):

Temporarily Non Available:

OK Cancel

Page ID: dlqEnrlAddLocation(Provider)

Click on the **Primary Practice Location** hyperlink (in blue).

Click **Add Address**.

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Add

To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink.

Locations List

Filter By

Go

Save Filters

My Filters

Doing Business As	Location Type	Location Details	End Date
	Primary Practice Location	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Save

To add additional addresses, click 'Add Address' button.

Location Details

Doing Business As:

Phone Number: (999) 999-9999 * Extn:

Web Page:

Handicap Accessible: No

Accept 835(reported at EIN/TIN level): No

End Date: 12/31/2999

Location Code: 01

Fax Number:

Office Hours:

Language(s) Spoken: English Arabic Chinese

Location Type: Primary Practice Location

Email Address:

Communication Preference: CHAMPS Notice

Add Address

Address List

Address Type

Address

End Date

Location

320 S WALNUT ST, LANSING, MICHIGAN 48933

12/31/2999

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

In the **Type of Address** drop down menu, select **Correspondence**.

***All correspondences from the Home Help program will be sent to the address entered here; therefore, enter the address where your agency regularly receives mail.*

If that address is the same as the one entered previously, simply select **Copy This Location Address** next to the **Location Address**.
Click **OK**.

The image displays two screenshots of a web application interface for adding a provider location address. Both screenshots show the 'Add Provider Location Address' form for 'Helping Hands Chore Services' with Application ID 20150528999673.

Top Screenshot: The 'Type of Address' dropdown menu is open, showing options: '--SELECT--', '--SELECT--', 'Correspondence' (highlighted), 'Pay To', and 'Remittance Advice'. The 'Location Address' field is empty. Below the dropdown, instructions state: 'If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWNR 1111 or DRAWER 1111)' and 'If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)'. The 'Address Line 1' and 'Address Line 2' fields are empty.

Bottom Screenshot: The 'Type of Address' dropdown menu is closed, and 'Correspondence' is selected. The 'Location Address' field now contains the text 'Copy This Location Address' (highlighted with a red box). The 'Address Line 1' field contains '320 S WALNUT ST' and the 'City/Town' dropdown menu is set to 'LANSING'. The 'OK' button is highlighted with a red box.

Click **Add Address**.
Select **Pay To** in **Type of Address**.
Enter the required information indicated by the asterisk (*).
Click **OK**.

CHAMPS My Inbox Provider

Scott, Sarah Quick Find Note Pad External Links My Favorites Print Help

MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201 Name: Helping Hands Chore Services

Close Save To add additional addresses, click "Add Address" button.

Location Details

Doing Business As:

Phone Number: (517) 373-2076 * Extn:

Web Page:

Handicap Accessible: No

Accept 835 (reported at EIN/TIN level): No

End Date: 12/31/2999

Location Code: 01

Fax Number:

Office Hours:

Location Type: Primary Practice Location

Email Address:

Communication Preference:

Language(s) Spoken: English Arabic Chinese

(For Multiple Selection, use Ctrl Key)

Facility Details

State Facility ID:

Fiscal Year End Date: 12/31 * (mm/dd)

Licensed Medicare Bed(s):

Licensed Medicaid/Medicare Bed(s):

Ventilator Dependent Unit(s):

Swim

Temporarily Non A

Address List

Add Address

Address Type

Correspondence

Location

Page ID: pgEnrollmentLocationGeneral

Add Provider Location Address

Application ID: 20150716126201 Name: Helping Hands Chore Services

Type of Address: Pay To

Location Address:

End Date:

If a department or drawer is required, please enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWNR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1: 320 S WALNUT ST * (Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town:

State/Province:

County:

Country: UNITED STATES

Zip Code: 48933 - 2014

Page ID: dlgEnrlLocationAddress(Provider)

OK Cancel

Notice the Correspondence, Location and Pay To rows have addresses.

Click **Save**.

Click **Close** on the next two screens to go back to the list of steps (Not shown).

The **Close** button is on the top left corner.

CHAMPS < My Inbox > Provider >

Scott, Sarah > Quick Find > Note Pad > External Links > My Favorites > Print > Help

MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201 Name: Helping Hands Chore Services

Close **Save** To add additional addresses, click "Add Address" button.

Doing business as: _____ Location Code: 01 Location type: Primary Practice Location

Phone Number: (517) 373-2076 * Extn: _____ Fax Number: _____ Email Address: _____

Web Page: _____ Office Hours: _____ Communication Preference: _____

Handicap Accessible: No Accept 835 (reported at EIN/TIN level): No

Language(s) Spoken: English Arabic Chinese

End Date: 12/31/2999

Facility Details

State Facility ID: _____ Fiscal Year End Date: 12/31 * (mm/dd)

Licensed Medicare Bed(s): _____ Licensed Medicaid/Medicare Bed(s): _____ Ventilator Dependent Unit(s): _____

Swing Bed(s): _____ Acute Care Bed(s): _____ Licensed LTC Unit(s): _____ (Long Term Care)

Temporarily Non Available: _____ Distinct Part Unit: None *

Address List

+ Add Address

Address Type	Address	End Date
Correspondence	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999
Location	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999
Pay To	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999

Delete View Page 1 Page Count: 1 Save To XLS Viewing Page: 1 << First < Prev > Next >> Last

Click on **Step 3: Add Specialties** hyperlink
Click **Add**.

Application ID: 20150709666544

Name: Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency					
Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.					
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	

Application ID: 20150528999673

Name: Helping Hands Chore Services

View Page

Close

Add

Specialty/Subspecialty List		
Filter By <input type="text"/> <input type="text"/> <input type="button" value="Go"/> <input type="button" value="Save Filters"/> <input type="button" value="My Filters"/>		
<input type="checkbox"/>	Specialty/Subspecialty ▲ ▼	Provider Type ▲ ▼
No Records Found!		

Choose **01-** for **Location**.

For both **Provider Type** and **Specialty**, choose **Home Help FAO**.

Click **OK**.

***NOTE: FAO is an acronym for Facility/Agency/Organization.

Print Help

Application ID: 20150528999673Name: Helping Hands Chore Services

Add Specialty/Subspecialty

Location: 01- *
Provider Type: HOME HELP FAO *
Specialty: HOME HELP FAO *
End Date:

Add Subspecialty

Available Subspecialties

Associated Subspecialties *


No Subspecialty

>>
<<

OK Cancel

Page ID: dlgEnrlAddSpecialties(Provider)

Steps 4-6 are optional; most agencies do not need to complete these steps.
Click **Step 7: Add Provider Controlling Interest/Ownership Details** hyperlink.



[My Inbox](#) [Provider](#)

Scott, Sarah

[Quick Find](#) [Note Pad](#) [External Links](#) [My Favorites](#) [Print](#) [Help](#)

[MyInbox](#) > [New Enrollment](#) > [Atypical Agency Enrollment](#)

Application ID: 20150716126201Name: Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.


Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/16/2015	07/16/2015	Complete	
Step 2: Add Locations	Required	07/16/2015	07/16/2015	Complete	
Step 3: Add Specialties	Required	07/16/2015	07/16/2015	Complete	
Step 4: Add License/Certification/Other	Optional			Complete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Optional			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1GoPage Count: 1SaveToXLS

Viewing Page: 1

[First](#) [Prev](#) [Next](#) [Last](#)

Click on the **Add** button to add a Managing Employee owner.



My Inbox

Provider

Scott, Sarah

Quick Find

Note Pad

External Links

My Favorites

Print

Help

MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201Name: Helping Hands Chore Services

Close

Add

Owners List

Filter By

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
No Records Found !				

Add Other Owned Entity

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By

Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

Choose **Managing Employee** in the **Owner Type** drop down menu.
Enter the required information, indicated by the asterisk (*).
Click **Validate Address** button (you *cannot* go any further without this).
Click **OK**.

***NOTE: Enter the percentage of the agency owned by the Managing Employee.

***NOTE: Entering the **Zip Code** will automatically update **State, City/Town, and County**.

The screenshot shows a web application window titled "Provider Controlling Interest/Ownership". At the top, it displays "Application ID: 20150528999673" and "Name: Helping Hands Chore Services". The form is divided into two main sections. The left section contains fields for "Owner Type" (a dropdown menu with "Managing Employee" selected), "SSN", "Legal Entity Name", "First Name", "Suffix", "Phone Number", and "Start Date". The right section contains fields for "Percentage Owned", "EIN/TIN", "Entity Business Name", "Last Name", "DOB", "Email", and "End Date". Below these are address fields: "Address Line 1", "Address Line 2", "Address Line 3", "State/Province", "City/Town", "County", and "Zip Code". At the bottom right, there are buttons for "Validate Address", "OK", and "Cancel". Red boxes highlight the "Owner Type" dropdown, the "Percentage Owned" field, the "Address Line 1" field, the "State/Province" dropdown, the "Zip Code" field, and the "Validate Address" button. The "OK" button is also highlighted with a red box.

Print Help

Application ID: 20150528999673 Name: Helping Hands Chore Services

Provider Controlling Interest/Ownership

Owner Type: *
SSN:
Legal Entity Name:
First Name:
Suffix:
Phone Number:
Start Date:
Address Line 1: *
Address Line 2:
Address Line 3:
State/Province: *
City/Town: *
County: *
Zip Code: *
Validate Address **OK** **Cancel**

Page ID: dlgEnrlmntAddOwner(Provider)

Click on the **Add** button to add a Board of Director, Officer, or Principle Owner.

My Inbox

Provider

Scott, Sarah

Quick Find

Note Pad

External Links

My Favorites

Print

Help

Myinbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201Name: Helping Hands Chore Services

Close

Add

Owners List

Filter By

Go

Save Filters

My Filters

<input type="checkbox"/>	Owner SSN/EIN/TIN ▲▼	Owner Information ▲▼	Type ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/>	123456789	Preston, Bill	Managing Employee	07/16/2015	12/31/2999

Delete

View Page: 1

Go

Page Count: 1

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Add Other Owned Entity

List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By

Go

Save Filters

My Filters

<input type="checkbox"/>	Other Owner EIN/TIN ▲▼	Other Owner Information ▲▼	Address ▲▼
--------------------------	---------------------------	-------------------------------	---------------

No Records Found!

Choose **Board of Directors/Officers/Principles** in the **Owner Type** drop down menu.

Enter the required information, indicated by the asterisk (*).

Click **Validate Address** button (you *cannot* go any further without this).

Click **OK**.

***NOTE: Enter the percentage of the agency owned by the BoD/Officers/Principles.

***NOTE: Entering the **Zip Code** will automatically update **State, City/Town, and County**


The screenshot shows a web form titled "Provider Controlling Interest/Ownership" for "Helping Hands Chore Services". The form contains several fields, some of which are highlighted with red boxes to indicate required information:

- Owner Type:** A dropdown menu with "Board of Directors/Officers/Principles" selected.
- Percentage Owned:** A text input field with an asterisk (*).
- Address Line 1:** A text input field with an asterisk (*).
- State/Province:** A dropdown menu with "OTHER" selected and an asterisk (*).
- Country:** A dropdown menu with "UNITED STATES" selected and an asterisk (*).
- Zip Code:** A text input field.
- Validate Address:** A button with a checkmark icon.
- OK:** A button with a checkmark icon.
- Cancel:** A button with a circle icon.

Other fields include SSN, Legal Entity Name, First Name, Suffix, Phone Number, Start Date, EIN/TIN, Entity Business Name, Last Name, DOB, Email, End Date, Address Line 2, City/Town, and County. The form also includes a "Print" button and a "Help" link in the top left corner.

Page ID: dlGEnrlmntAddOwner(Provider)

Click on the **Add** button to add either an Individual or Corporate Owner.



[My Inbox](#) [Provider](#)

Scott, Sarah

[Quick Find](#) [Note Pad](#) [External Links](#) [My Favorites](#) [Print](#) [Help](#)

[MyInbox](#) > [New Enrollment](#) > [Atypical Agency Enrollment](#) > [General](#)

Application ID: 20150716126201Name: Helping Hands Chore Services

Close

Add

Owners List

Filter By

Go

Save Filters

My Filters

Owner SSM/EIN/TIN	Owner Information	Type	Start Date	End Date
123456789	Preston, Bill	Managing Employee	07/16/2015	12/31/2999
123456789	Preston, Bill	Board of Directors/Officers/Principles	07/16/2015	12/31/2999

Delete

View Page: 1

Go

Page Count: 1

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Add Other Owned Entity

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By

Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
---------------------	-------------------------	---------

No Records Found !

Choose either a **Corporate** option OR **Individual** option in the **Owner Type** drop down menu.

Enter the required information, indicated by the asterisk (*).

Click **Validate Address** button (you *cannot* go any further without this).

Click **OK**.

***NOTE: Enter the percentage of the agency owned by the Corporate/Individual Owner.

***NOTE: Entering the **Zip Code** will automatically update **State, City/Town, and County**

The screenshot shows a web form titled "Provider Controlling Interest/Ownership" for "Helping Hands Chore Services". The form contains several sections with fields marked with an asterisk (*) to indicate required information. Red boxes are drawn around the following fields:

- Owner Type:** A dropdown menu with "Corporate - Charitable 501(c)3" and "Corporate - Non Charitable" selected.
- Percentage Owned:** A text input field.
- Address Line 1:** A text input field.
- City/Town:** A dropdown menu with "OTHER" selected.
- Zip Code:** A text input field.
- Validate Address:** A button with a checkmark icon.
- OK:** A button with a checkmark icon.

Other visible fields include SSN, Legal Entity Name, First Name, Suffix, Phone Number, Start Date, EIN/TIN, Entity Business Name, Last Name, DOB, Email, End Date, Address Line 2, Address Line 3, State/Province, and Country. The form also includes a "Print" button and a "Help" link in the top left corner.

Page ID: dlGEnrlmntAddOwner(Provider)

Click on the **Managing Employee** SSN hyperlink (in blue).

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Owners List

Add

Filter By Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
<input type="checkbox"/> 123456789	Preston, Bill	Managing Employee	06/04/2015	12/31/2999
<input type="checkbox"/> 123456789	Preston, Bill	Board of Directors/Officers/Principles	06/04/2015	12/31/2999
<input type="checkbox"/> 123456789	Preston, Bill	Individual	06/04/2015	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

Click **Add**.

Select **Your Name** under the **Owner Name** drop down menu.

Select **None** under the **Relationship** drop down menu.

Click **OK**.

***NOTE: If more than one name is listed under **Owner Name**, you will have to repeat these steps for the other names [i.e., click **Add**, select next name in **Owner Name**, choose the relationship].

Application ID: 20150528999673 Name: Helping Hands Chore Services

SSN: 123456789 EIN/TIN:

Legal Entity Name: (As shown on the Income Tax Return) Entity Business Name: (Doing Business As)

First Name: Bill * Last Name: Preston *

Application ID: 20150528999673 Name: Helping Hands Chore Services

Modify Owner Relationship

Owner Name: PrestonBill

Relationship: None

Page ID: dlgOwnerRelationship(Provider)

Page ID: pgEnrlmntManageOwner(Provider) Environment: UAT (Server: wtw301.85 - Build: R8_5.4) Server Time: 06/02/2015 10:26:29 EDT

Your name will be added to the **Owner Name** column.
At the bottom of the page, click on the **“Final Adverse Legal Actions/Convictions Disclosure”** hyperlink.

Application ID: 20150528999673 Name: Helping Hands Chore Services

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *


Country: *

Zip Code: -

☒ Inactivate

Relationship

Filter By:

<input type="checkbox"/>	Owner Name	Modified Date	Operational Status
<input type="checkbox"/>	 Bill Preston	05/28/2015 16:37:09	Active

View Page: Viewing Page: 1

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

Read the **Final Adverse Legal Actions/Convictions** statement.
Answer the question at the bottom by choosing **yes** or **no** and comment if necessary.
Click **OK**.

Print Help

Application ID: 20150716126201

Name: Helping Hands Chore Services

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

CONVICTIONS

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you?

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? ☐ Yes ☐ No

Comments (optional):

OK Cancel

Click **Close** to go back to the **Owner's List** screen.
Click on the **BoD/Officers/Principles** SSN hyperlink (in blue).

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Save

View Screening Result

SSN: 123456789

EIN/TIN:

Legal Entity Name:

(As shown on the Income Tax Return)

Entity Business Name:

(Doing Business As)

First Name: Bill

Last Name: Preston

Suffix:

DOB: 01/01/1960

Phone Number: (517) 373-2076

Extn:

Start Date: 05/28/2015

Email:

End Date: 12/31/2999

Address Type: Home Address

Address Line 1: 320 S WALNUT ST

Address Line 2:

(Enter Street Address or PO Box Only)

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Owners List

Add

Inactive

Page ID: pgEnrlm

Filter By

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
<div>123456789</div>	Preston, Bill	Managing Employee	06/04/2015	12/31/2999
<div>123456789</div>	Preston, Bill	Board of Directors/Officers/Principles	06/04/2015	12/31/2999
<div>123456789</div>	Preston, Bill	Individual	06/04/2015	12/31/2999

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Click **Add**.

Select **Your Name** under the **Owner Name** drop down menu.

Select **None** under the **Relationship** drop down menu.

Click **OK**.

***NOTE: If more than one name is listed under **Owner Name**, you will have to repeat these steps for the other names [i.e., click **Add**, select next name in **Owner Name**, choose the relationship].

Application ID: 20150528999673 Name: Helping Hands Chore Services

SSN: 123456789 EIN/TIN:

Legal Entity Name: (As shown on the Income Tax Return) Entity Business Name: (Doing Business As)

First Name: Bill * Last Name: Preston *

Application ID: 20150528999673 Name: Helping Hands Chore Services

Modify Owner Relationship

Owner Name: PrestonBill

Relationship: None

Page ID: dlgOwnerRelationship(Provider)

Page ID: pgEnrlmntManageOwner(Provider) Environment: UAT (Server: wtw301.85 - Build: R8_5.4) Server Time: 06/02/2015 10:26:29 EDT

Your name will be added to the **Owner Name** column.
At the bottom of the page, click on the **“Final Adverse Legal Actions/Convictions Disclosure”** hyperlink.

Application ID: 20150528999673 Name: Helping Hands Chore Services

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

☒ Inactivate

Relationship

Filter By:

Owner Name	Modified Date	Operational Status
<input type="checkbox"/> Bill Preston	05/28/2015 16:37:09	Active

View Page:

Viewing Page: 1

« First < Prev > Next » Last

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

Read the **Final Adverse Legal Actions/Convictions** statement.
Answer the question at the bottom by choosing **yes** or **no** and comment if necessary.
Click **OK**.

Help

Application ID: 20150528999673Name: Helping Hands Chore Services

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

CONVICTIONS

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.
Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you?

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? ☐ Yes ☐ No Comments (optional):

Page ID: dlOwnerCheckList(Provider)

Click **Close** to go back to the **Owner's List** screen.
Click on the **Individual/Corporate** SSN hyperlink (in blue).

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Save

View Screening Result

SSN: 123456789

EIN/TIN:

Legal Entity Name:

(As shown on the Income Tax Return)

Entity Business Name:

(Doing Business As)

First Name: Bill

Last Name: Preston

Suffix:

DOB: 01/01/1960

Phone Number: (517) 373-2076

Ext:

Email:

Start Date: 05/28/2015

End Date: 12/31/2999

Address Type: Home Address

Address Line 1: 320 S WALNUT ST

Address Line 2:

(Enter Street Address or PO Box Only)

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Owners List

Add

Inactive

Page ID: pgEnrlm

Filter By

Go

Save Filters

My Filters

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Click **Add**.

Select **Your Name** under the **Owner Name** drop down menu.

Select **None** under the **Relationship** drop down menu.

Click **OK**.

***NOTE: If more than one name is listed under **Owner Name**, you will have to repeat these steps for the other names [i.e., click **Add**, select next name in **Owner Name**, choose the relationship].

Application ID: 20150528999673 Name: Helping Hands Chore Services

SSN: 123456789 EIN/TIN:

Legal Entity Name: (As shown on the Income Tax Return) Entity Business Name: (Doing Business As)

First Name: Bill * Last Name: Preston *

Application ID: 20150528999673 Name: Helping Hands Chore Services

Modify Owner Relationship

Owner Name: PrestonBill

Relationship: None

Page ID: dlgOwnerRelationship(Provider)

Page ID: pgEnrlmntManageOwner(Provider) Environment: UAT (Server: wtw301.85 - Build: R8_5.4) Server Time: 06/02/2015 10:26:29 EDT

Your name will be added to the **Owner Name** column.
At the bottom of the page, click on the **“Final Adverse Legal Actions/Convictions Disclosure”** hyperlink.

Application ID: 20150528999673 Name: Helping Hands Chore Services

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

☒ Inactivate

Relationship

Filter By:

Owner Name	Modified Date	Operational Status
<input checked="" type="checkbox"/> Bill Preston	05/28/2015 16:37:09	Active

View Page: Viewing Page: 1

« First < Prev Next > Last

“Final Adverse Legal Actions/Convictions Disclosure”

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link “Final Adverse Legal Actions/Convictions Disclosure” to read and answer the disclosure.	Not Completed		

Read the **Final Adverse Legal Actions/Convictions** statement.
Answer the question at the bottom by choosing **yes** or **no** and comment if necessary.
Click **OK**.

Help

Application ID: 20150528999673Name: Helping Hands Chore Services

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

CONVICTIONS

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.
Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

2. Any revocation or suspension of accreditation.

3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

4. Any current Medicaid payment suspension under any Medicaid enrollment.

5. Any Medicaid revocation of any Medicaid provider billing number.

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you?

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? ☐ Yes ☐ No Comments (optional):

Page ID: dlqOwnerCheckList(Provider)

Click **Save**.
Click **Close**.
Click **Close**.

Application ID: 20150528999673

Name: Helping Hands Chore Services



Close



Save

View Screening Result

SSN: 123456789

EIN/TIN:

Legal Entity Name:

(As shown on the Income Tax Return)

Entity Business Name:

(Doing Business As)

First Name:

Bill *

Last Name:

Preston *

Suffix:

DOB:

01/01/1960 *

Phone Number:

(517) 373-2076 *

Extn:

Email:

Start Date:

05/28/2015 *

End Date:

12/31/2999

Application ID: 20150528999673

Name: Helping Hands Chore Services



Close

Owners List



Add

Filter By



Go



Save Filters



My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
▲▼	▲▼	▲▼	▲▼	▲▼
123456789	Preston, Bill	Managing Employee	06/04/2015	12/31/2999
123456789	Preston, Bill	Board of Directors/Officers/Principles	06/04/2015	12/31/2999
123456789	Preston, Bill	Individual	06/04/2015	12/31/2999



Delete

View Page: 1



Go



Page Count



Save To XLS

Viewing Page: 1



First



Prev



Next



Last

Steps 8-10 are optional. Most agencies do not need to complete these steps.

Click on the **Step 11: Complete Enrollment Checklist** hyperlink.

Application ID: 2015070966544

Name: Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required	07/09/2015	07/09/2015	Complete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	07/09/2015	07/09/2015	Complete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	07/09/2015	07/09/2015	Complete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1



Page Count: 1



Viewing Page: 1

« First

◀ Prev

Next ▶

» Last

Answer the **Provider Checklist** questions by choosing **Yes** or **No** in the drop down menus of the **Answer** column.

Click **Save**.

Click **Close**.

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Save

Provider Checklist

Question	Answer	Comments
Are you interested in working for other Home Help clients? (If you say no this will not affect your current work.)	<div>Yes</div> <div>No</div> <div>Not Completed</div> <div>Yes</div> <div>No</div>	

| If you are interested in working for other clients do you authorize us to put your contact information on our Provider Registry List so that you can be contacted for additional work? | | |

| Do you want your name removed from our Provider Registry? | No | |

| Have you ever been removed or told that you cannot participate in a State funded program? If yes, please tell us what program and why. | No | |

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Click on the **Step 12: Submit Enrollment Application for Approval** hyperlink.
By clicking the **Next** button, you “agree that the information submitted as a part of the application is correct (Private and Confidential)”.

Application ID: 20150709666544

Name: Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required	07/09/2015	07/09/2015	Complete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	07/09/2015	07/09/2015	Complete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	07/09/2015	07/09/2015	Complete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required	07/09/2015	07/09/2015	Complete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:

Viewing Page: 1

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Next

Final Submission

Application ID: 20141203023112

Enrollment Type: HIPAA-Exempt Individual/Sole Proprietor

The information submitted for enrollment shall be verified and reviewed by the State.
During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).

Application Document Checklist

Forms/Documents

Special Instructions

I agree that the information submitted as a part of the application is correct (Private and Confidential).

Read the **Terms and Conditions (Enrollment Process)** statement.
Check the box at the *bottom* indicating you have read and agree to the terms.
Click **Submit Application**.

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Submit Application

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.



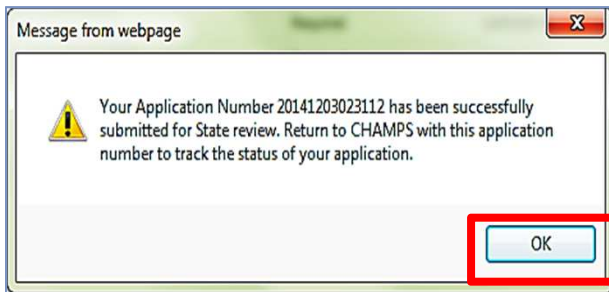
Terms and Conditions (Enrollment Process)



1. As an individual provider of Home Help services, I agree that the Medicaid beneficiary is considered the employer. I am not employed by the Michigan Department of Community Health (MDCH), the Department of Human Services (DHS), or the State of Michigan.
2. As a Home Help provider agency, I agree that the agency contract is with the Medicaid beneficiary. The agency contract is not with the Michigan Department of Community Health (MDCH), the Department of Human Services or the State of Michigan.
3. I agree that personal care services will be provided for a Michigan Medicaid beneficiary, as authorized by the Michigan Department of Human Services (DHS) according to the DHS Adult Services Comprehensive Assessment.
4. Under Section 3504 of the Internal Revenue Code, I agree to accept the Michigan Department of Community (MDCH) as the acting agent of the beneficiary for the deduction of withholding of FICA taxes. I understand that federal, state and city taxes are not withheld. I further agree to accept payments issued by MDCH as payment in full and not to seek or accept additional payments from the beneficiary or any other source.
5. I agree to return any payments received for Home Help services not provided. I understand that accepting payment for services I did not provide is fraudulent and could result in criminal charges.
6. I understand that the Home Help program is funded by Medicaid and payments will not be approved by the Department if the beneficiary's Medicaid eligibility is inactive.
7. In order to receive payment, I agree to keep and submit to MDCH, DHS or their designee, any and all records necessary to disclose the extent of services provided to the beneficiary.
8. Upon request, I agree to provide MDCH, DHS or their designee, any information regarding services or purchases for which payment was made.
9. Upon request, I agree to provide MDCH, DHS or their designee, any business transaction information as specified by 42 CFR 455.105.
10. I understand I will be subject to a criminal history screening and may not qualify to be a home help provider.
11. I agree to cooperate with MDCH, DHS or their designee, regarding any audits, investigations or inquiries related to Home Help services provided.
12. I agree to report any changes relative to the beneficiary including but not limited to hospitalizations, nursing home stays or discontinuation of services.
13. I agree to comply with the privacy, security and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information (PHI), including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR parts 106 and 164, Subparts A, C, and E).
14. I agree to comply with the provisions of 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.

☒ By checking this, I acknowledge that I have read the terms and agreement and I agree to fully comply with all program requirements.

Click **OK** in the textbox that will pop up.
You will be sent back to the **Enroll Provider** page.
Click **Close**.
This will return you to the CHAMPS home page.

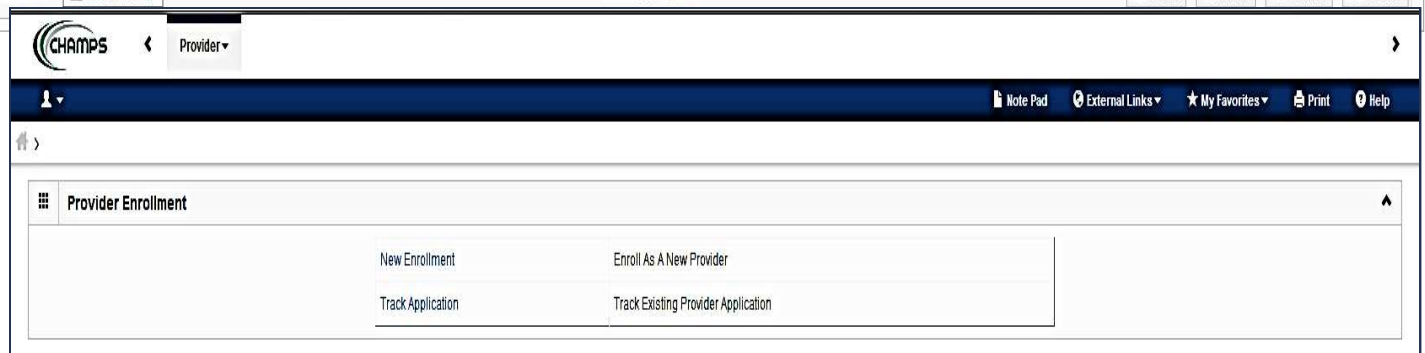


Name: Helping Hands Chore Services

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required	07/09/2015	07/09/2015	Complete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	07/09/2015	07/09/2015	Complete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	07/09/2015	07/09/2015	Complete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required	07/09/2015	07/09/2015	Complete	
Step 12: Submit Enrollment Application for Approval	Required	07/09/2015	07/09/2015	Complete	

View Page: 1 Go Page Count: 1 SaveToXLS Viewing Page: 1 << First < Prev Next > >> Last



Tracking Your Application

How to Verify the Status of Your Application

If you would like to check the status of your application, you can do so from the CHAMPS homepage:

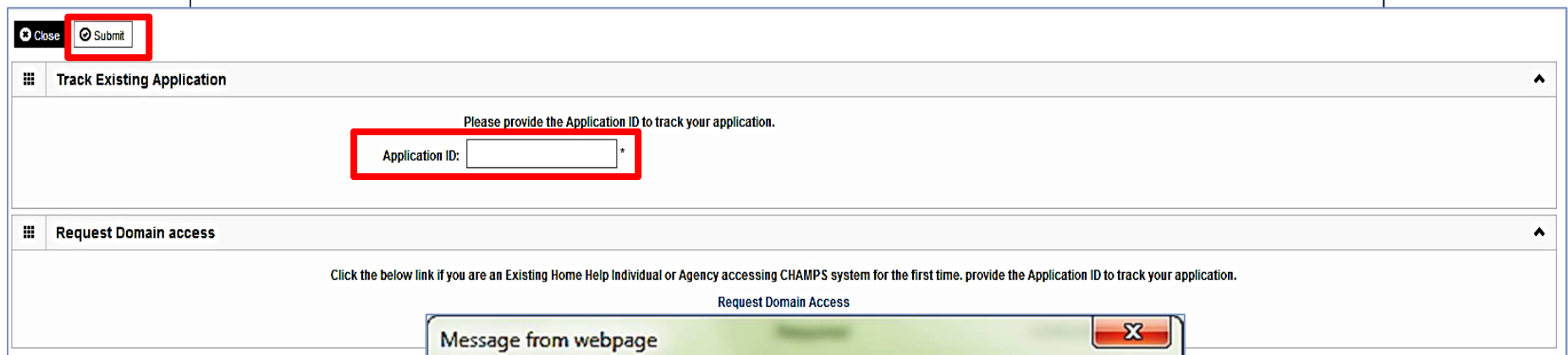
On the home page, click the **Track Application** hyperlink (in blue).

Enter your Application ID number. Click **Submit**.

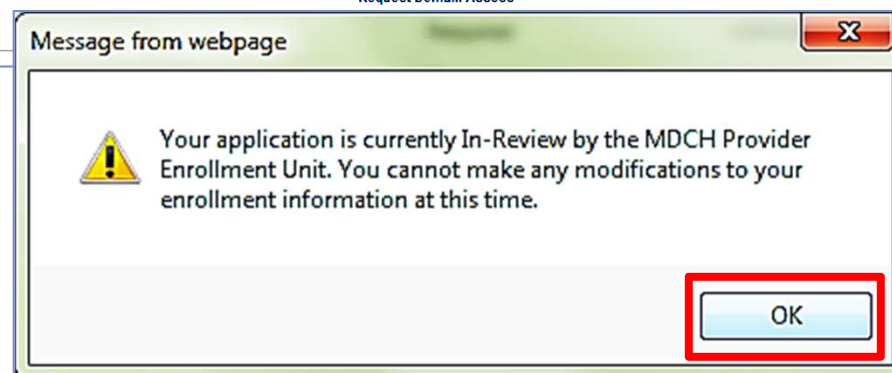
A text box will pop up with a statement about the status of your application. Click **OK**.



The screenshot shows the CHAMPS Provider Enrollment page. The top navigation bar includes the CHAMPS logo, a 'Provider' dropdown menu, and a user profile icon. A secondary navigation bar contains links for 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. The main content area is titled 'Provider Enrollment' and contains a table with four links: 'New Enrollment', 'Enroll As A New Provider', 'Track Application' (highlighted with a red box), and 'Track Existing Provider Application'.



The screenshot shows the 'Track Existing Application' form. At the top left, there are 'Close' and 'Submit' buttons, with the 'Submit' button highlighted by a red box. The form title is 'Track Existing Application'. Below the title, a message reads: 'Please provide the Application ID to track your application.' Below this message is a text input field labeled 'Application ID:' with a red box around it. At the bottom of the form, there is a section titled 'Request Domain access' with a message: 'Click the below link if you are an Existing Home Help Individual or Agency accessing CHAMPS system for the first time. provide the Application ID to track your application.' and a link labeled 'Request Domain Access'.



The screenshot shows a 'Message from webpage' dialog box. It has a green title bar with a close button. The message text reads: 'Your application is currently In-Review by the MDCH Provider Enrollment Unit. You cannot make any modifications to your enrollment information at this time.' There is a yellow warning icon to the left of the text. At the bottom right, there is an 'OK' button highlighted with a red box.

Provider Resources

- Home Help Provider Support Hotline:
1-800-979-4662
- Home Help Provider Support Email:
ProviderSupport@Michigan.gov
- Home Help Provider FAQ document: Go to Michigan.gov/homehelp and click on the Home Help Frequently Asked Questions (FAQs) link under the Additional Home Help Resources heading